Health Home PMPM Fee Schedule:

Member's Tier	PMPM Rate
Tier 1 (1-3 chronic conditions)	$12.80
Tier 2 (4-6 chronic conditions)	$25.60
Tier 3 (7-9 chronic conditions)	$51.21
Tier 4 (10 or more chronic conditions)	$76.81

When is it appropriate to submit a PMPM Report for Health Home Services?

The criteria required to receive a monthly PMPM payment is:

- The member meets the eligibility requirements as identified by the provider and documented in the member's electronic health record (EHR).
- The member has full Medicaid benefits at the time the PMPM payment is made.
- The member has agreed and enrolled with the designated health home provider.
- The Health Home provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards.
- The minimum service required to merit a Patient Management PMPM payment is that the person has received care management monitoring for treatment gaps defined as Health Home Services in this State Plan, or a covered service defined in this state plan was provided that was documented in the member's EHR.
- The Chronic Condition Health Home will attest, by a monthly claim submission, that the minimum service requirement is met. The patient medical record will document Chronic Condition Health Home Service activity and the documentation will include either a specific entry, at least monthly, or an ongoing plan of activity, updated in real time and current at the time of claim submission.

The PMPM payment is a reflection of the added value provided to members receiving this level of care and is risk adjusted based on the level of acuity assigned to each patient based on the provider's overall health assessment using the PTAT guidelines published by the State.

Chronic Condition Health Home Services Guide

Health Home Service	By providing one or more of the Health Home services listed below during a given month you may attest that you have provided Health Home services authorizing IME to pay for your PMPM	Role Responsible
Comprehensive Care Management	Managing the Comprehensive Care for each member enrolled in the health home includes: • Personal provider • Pre-visit planning • Individualized care plan that addresses barriers and goals not met (updated at each chronic care visit) • Identify care management support needs • Follow-up with patients that do not keep appointment	Care team
Care Coordination	Care Coordination includes: • Track referrals to specialist to complete the referral loop • Obtain specialists report • Ask about self-referrals and follow up to obtain the specialist report	Care Coordinator
Health Promotion	Health Promotion includes: • Coordinating or providing behavior change interventions aimed at supporting health management • Improving disease results • Disease prevention, safety and overall healthy lifestyle.	Health Coach
Comprehensive Transitional Care	Comprehensive Transitional Care from inpatient (hospital) to other settings includes: • Identify and share information with hospitals ie: sending records to hospital and obtaining records when patient discharged. • Follow up with patients who have been seen in the ER or admitted to the hospital • Transition from pediatric to adult level of care to long term care or end of life care • Review and reconcile meds at every transition	Care Team
Individual and Family Support Services	Culturally appropriate communication with patients, families, caregivers or authorized representatives for Individual and Family support includes: • Provide educational resources that can be patient specific • Assist with setting self-management goals • Provide self-management tools • Provide information for new meds by using models such as teach back • Assess understanding of medication, response to medications and barriers to taking medication as prescribed	Health Coach
Referral to Community and Social Support Services	Referral to Community and Social Support Services includes: • Coordinate or provide recovery services and social health services available in the community • Understanding eligibility for various health care programs, disability benefits • Identifying housing programs • Track number of referrals to community services • Arrange or provide treatment for substance abuse disorders or oral health • Offer health education and peer support	Care Coordinator with the help of an outside case manager or community care team